CHARGING FEES FOR FAMILY PLANNING SERVICES

Summary

This brief examines the prospects for mobilizing revenues for family planning services by instituting or increasing fees charged to clients. The following issues are addressed:

- assessment of the impact of fees on demand for services;
- comparison of the impact of fees on demand for health care with their impact on demand for family planning;
- assessment of the potential for maintaining demand by improving service quality; and

assessment of the potential for using means testing to ensure access for the poor.

Richard Lord

QUESTION #1:

Do fees reduce the use of family planning services?

The concern with charging or increasing fees for family planning services is that these may discourage couples from using contraception. The evidence is mixed: Some early studies suggest that price has a minimal impact on demand; others suggest a dramatic impact.[1,2] It is likely that these differences reflect measurement error rather than real differences in the impact of price on demand.

Recent studies of the impact of price on family planning use in sub-Saharan Africa have also had mixed results, as illustrated in Table 1.

These studies suggest that prices have a relatively limited impact on demand for family planning in sub-Saharan Africa. However, this may be because prices are currently so low; it may be that larger price changes, to the higher price levels typical of the commercial sector, will have a more significant impact on demand. These findings also indicate why price is so rarely cited in Demographic and Health Surveys (DHS) as a reason for not using or not intending to use contraception.[3] If prices are low or nonexistent, then affordability will not be an important deterrent to use; however, large price increases to near-commercial levels might have a more significant impact on demand.

More detailed information, preferably based on systematic study of behavior change in response to actual price increases rather than on cross-sectional data, is necessary before broad policy conclusions may be drawn on the impact of prices on contraceptive use. Based on the limited and flawed information available, the most we may conclude is that modest increases in fees from a low level are unlikely to dissuade service use, but larger increases in fees to near-commercial levels might have a significant negative impact on use.

QUESTION #2:

Are certain groups more likely to stop using services when fees are introduced or increased?

Available data suggest that modest increases in fees from low levels will have a limited impact on service use among the general population of family

Table 1. Impact of Price on Family Planning Use in Sub-Saharan Africa

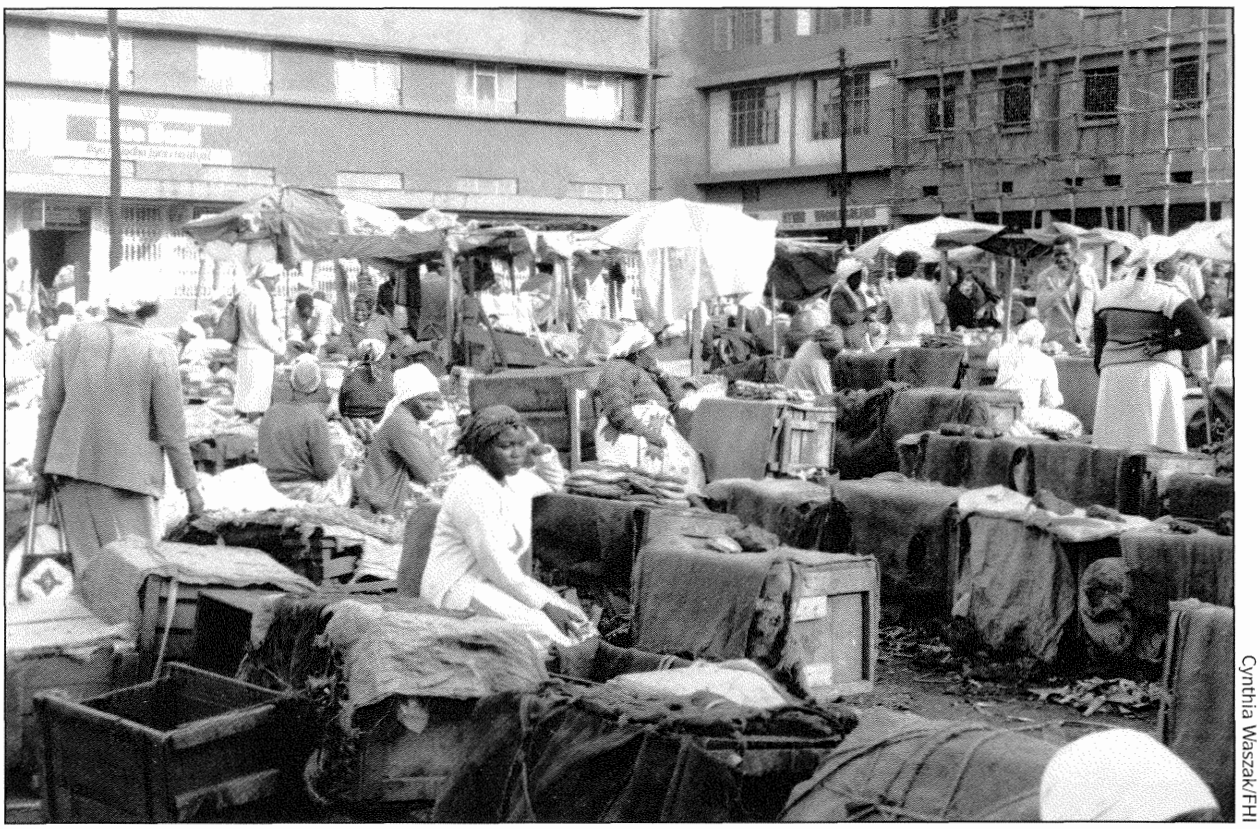
Country	*Methodology*	*Results*
Tanzania[4]	Cross-sectional data; price of contraception proxied using distance to nearest facility.	Findings with respect to the impact of price on demand not consistent.
Zimbabwe[5]	Cross-sectional data; price of oral contraceptives used as price variable.	Price had no impact on demand.
Ghana[6]	Cross-sectional data; family planning consultation fee and price of spermicides used to construct price variables.	Family planning consultation fees had no impact on use, but the price of spermicides in the private sector had a negative impact on use.
Nigeria[7]	Cross-sectional data; actual price of methods used.	No relationship was found between contraceptive use and the level of outpatient or registration fees, but the price of methods at pharmacies was associated with lower use.

planning clients. It is possible, however, that certain groups — such as poor women and young people, who have least access to resources — will react more strongly, even to small price increases.

There is a growing body of evidence that user fees may cause large reductions in service use among individuals in lower income groups, and particularly among the very poor.[8,9] It is also possible that fees will affect service use among women more than men, given unequal gender relations and women's lesser say in decisions regarding household resource allocation. Unfortunately, there is very limited information to substantiate this. Work under way in Navrongo, Ghana, suggests that women's fear of negotiation with their partners may deter them from requesting funds for contraceptives. And in Senegal, research on the impact of prices for primary health care found that women were more affected by fees for care than were men.[10]

No data are available on the differential impact of fees on different age groups. One recent study found that sexually active adolescents in Cameroon were more likely to use condoms they had paid for than those they had received for free.[11] However there was no attempt to determine the role prices play in influencing demand for condoms. If prices have a strong deterrent effect, free distribution may be preferable even if these condoms are more likely to be wasted.

Even when research suggests that prices have a limited impact on demand, efforts should be made to ascertain whether the result based on all clients



Cynthia Waszak/FHI

masks significant variations by income level, gender or age. This is particularly important in the case of gender, since the majority of people who purchase contraceptives are women. Because needs for family planning services among young people are substantial and increasing, it is also important that we improve our understanding of the factors that influence use of services among this group.

QUESTION #3:

What do we know about willingness to pay for health and family planning services?

There is a substantial literature on the impact of prices on demand for health care. While the results are mixed and of questionable validity,[12] it is possible to draw the following conclusion: People are more willing to pay fees for curative health care than for family planning.

Why are individuals willing to pay more for health care than for family planning?

Consumers are likely to perceive the benefits they gain from curative health care, preventive health care and family planning very differently. Curative care is generally sought in response to an immediate and sometimes urgent health need, so its benefits are immediate and personal. Preventive care, on the other hand, has effects that are not immediate and that may benefit many others besides the individual receiving care. Reactions to prices for family planning are more likely to resemble reactions to prices for preventive care than to fees for curative care.[13] However, in the case of family planning, individuals are attempting to prevent pregnancy rather than illness. The consequences of not taking action are very different in these two cases.

The results of a study in Burkina Faso are illustrative.[14] Nearly all households were willing to pay for improvements in equipment at health facilities, the maintenance of these facilities, and drugs to treat a range of common illnesses. Far fewer were willing to pay for contraceptives. Households were willing to pay amounts representing 5 percent to 10 percent of their total expenditures to improve the quality of health care, but less than .05 percent to improve the quality of family planning services.

Table 2. Impact of Quality on Demand for Family Planning Services in Sub-Saharan Africa

Country	*Result*
Tanzania[17]	Only two of a number of quality variables used (availability of pills and injectables) had a positive impact on use.
Zimbabwe[18]	Only two of a number of quality variables for clinics had a positive impact on use (the number of needles in stock and the number of nurses on site); only two variables of community-based distribution (CBD) program quality (whether or not CBD workers had a bicycle or had taken a training course) had an impact on use.
Ghana[19]	The results with respect to the impact of all quality variables on demand were "inconsistent and sometimes perverse."
Nigeria[20]	Quality variables had a limited impact on demand.

QUESTION #4:

Does improving service quality increase fee revenues?

There is a growing body of research that shows that quality plays a more important role than price in determining demand for health care. Because of this, it is suggested that the impact of service fees can be offset by quality improvements, which would increase the revenue generated by these fees.

In a study in Cameroon, for example, three of five health facilities introduced a user fee and quality improvements, while two introduced fees but did not improve quality.[15] While the fees did reduce demand in all five facilities, demand was less affected by fees in the facilities that made simultaneous quality improvements.

Do the costs of improving quality exceed potential fee revenues?

The cost of improving quality may be high. This is particularly true in sub-Saharan Africa, where initial quality levels are particularly low. In Niger, for example, the cost of improving drug availability in one district undergoing quality improvements was 2.5 times higher than the annual Ministry of Health budget.[16] If the primary purpose of fees is to raise revenue to cover existing costs, making the quality improvements necessary to sustain demand may make it impossible to achieve this objective.

Does quality have the same impact on demand for family planning as it does on demand for health care?

The impact of quality on demand for family planning as opposed to health care is not known with any certainty. Preliminary evidence suggests that quality has a limited and inconsistent impact on the use of family planning services. The family planning pricing studies described in Question #1 also assessed the impact of quality on demand.

The results of the four studies summarized in Table 2 indicate that quality has a less significant impact on demand for family planning services than one might expect. This may explain the results of the study in Burkina Faso described in Question #3, which found that far fewer individuals were willing to pay for improvements in family planning services than for improvements in health care.

In summary, the limited evidence available suggests that quality improvements may not reduce the negative impact that increasing family planning prices can have on demand.

QUESTION #5:

Is it possible to exempt the poor from fees?

Even if most people are able and/or willing to pay fees for family planning services, some people cannot. As noted above, there is evidence that fees may cause large reductions in service use among the poor, and particularly among the very poor. Some form of means testing is needed to identify those who cannot pay and ensure that they have access to services. This can be complicated; in some cases, the cost of designing and implementing a well-functioning means testing system can be so high that it offsets the revenues that could be gained from charging fees.

There is no information on the use of means testing in family planning programs. Evidence from the health sector indicates that means testing has not worked well, particularly in sub-Saharan Africa. One extensive review of means testing worldwide found that only ten of 28 programs

were effective, and only one of these was in sub-Saharan Africa.[21] The conditions required for effective means testing, such as formal wage records and adequate administrative infrastructure, tend not to exist in the region.[22]

In Africa, means testing systems tend to be decentralized and informal. Only two countries (Zimbabwe and Ethiopia) have official income ceilings for exemptions; two (Lesotho and Malawi) have specific landholding and/or livestock ownership criteria; 12 claim to provide exemptions but do not specify the criteria used; and eight are based on ad hoc local policy.[23,24] Most of these programs provide exemptions to many individuals who do not necessarily need them (e.g., health workers or civil servants), and do not provide exemptions to many who do.

A general lesson can be learned from this experience: If fees for family planning are instituted or increased in Africa, effective mechanisms are needed to ensure that the poor will continue to have access to services.

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About These Policy Briefs

This series of four policy briefs was written by Barbara Janowitz, Diana Measham and Caroline West. It was published by Family Health International with support from the Office of Sustainable Development, Bureau for Africa, U.S. Agency for International Development.

The briefs explore four key issues in the financing of family planning services in sub-Saharan Africa:

1) the need for additional funds for family planning in sub-Saharan Africa;

2) charging fees for family planning services;

3) expanding commercial sector participation in family planning; and

4) reducing costs and enhancing efficiency.

For more in-depth information, please request a copy of the 80-page report, *"Issues in the Financing of Family Planning Services in Sub-Saharan Africa,"* from: Publications Coordinator, Family Health International, P.O. Box 13950, Research Triangle Park, NC 27709 USA. The report is also available in full text on FHI's Web site at *http://www.fhi.org.*